

SELF CONCEPT AS A VARIABLE IN THE PREDICTION
OF TREATMENT OUTCOME

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by
Harold J. Green
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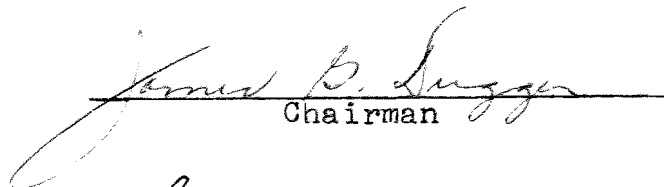
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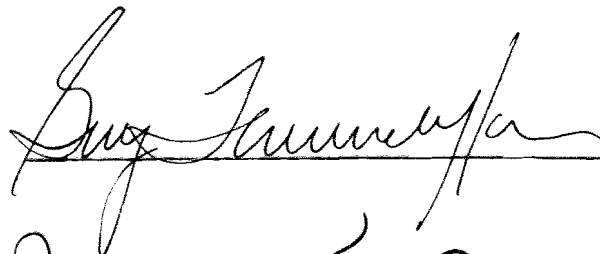
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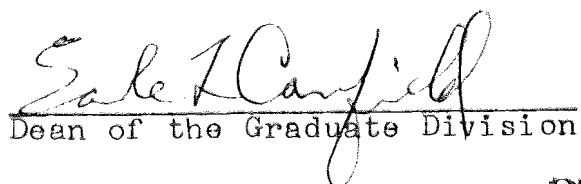
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CHAPTER I

INTRODUCTION

Many clinically derived criteria have been utilized in the prediction of treatment outcome for institutionalized psychiatric patients. None of these variable has been impressively effective. The purpose of this thesis is to investigate the question of whether a person's concept of self is an effective predictor of treatment outcome. If the efficacy of self concept measurement in the therapeutic community can be demonstrated, it would point the way for the incorporation of a valuable tool in the explanation and prediction of behavioral disorders and their consequences.

For the purpose of this thesis recidivism has been used as the indicator of overall post-hospital adjustment. The rationale for this usage was threefold: (1) The data collection and analysis was completed under the auspices of the Mental Health and Manpower Project (MHM), a federally supported research primarily concerned with the variables involved in treatment outcome (this project is jointly sponsored by the Colorado State University and the Fort Logan Mental Health Center, the latter being an opendoor, progressive, state mental hospital); (2) recidivism is a commonly used "hardcore" data collection criterion of post-hospital adjustment; (3) recidivism is easily operationalized.

The term "self" as used in modern psychology, has come

to have several somewhat different meanings. There appear to be two basically different common uses of the construct. The first usage refers to a group of psychological processes which govern a man's behavior, both external and internal--often designated as "self-as-process." The second meaning, that of "self-as-object," denotes a person's attitudes, feelings, perceptions, and evaluations of himself as an object: "In the former, the self is what a person does; the latter, on the other hand, is what a person thinks of himself."¹

The existence of two definitions of self has prompted several writers to use separate terms. The most common differentiation involves using "ego" to denote self-as-process, and "self" to refer to self-as-object. This convention, however, is not universal. In fact, some writers use the two terms in just the opposite manner, while others persist in using them interchangeably.² This study proposes to deal primarily with self-as-object, hence, the term "self concept" shall be used. Through the addition of the word "concept," it is hoped that object rather than process will be directly denoted. This is the convention suggested by Wylie (1961) whose book on self-as-object stands as the most complete review in the field.³

¹Radean W. Miskimins, "The Concept of Self and Psychopathology," (unpublished Doctoral Dissertation, The University of Colorado, Boulder, 1967), p. 5.

²Ibid.

³Ruth C. Wylie, The Self Concept (Lincoln: University of Nebraska Press, 1961), pp. 1-5.

Whenever one approaches the topic of theory, there is uncertainty as to what constitutes a theory. Problems of completeness, efficiency, operationalizeability, to name a few, are brought to the fore. Certainly the most extensive relevant theoretical framework in this area has to be that postulated by Carl Rogers. Although much of his writing is concerned with the process of therapy and the weighing of various techniques, there is to be found in his later works (e.g., 1951) a reasonably cohesive and complete theory regarding the self concept. He readily acknowledges considerable debt to the Organismic personality theorists and their emphasis upon self-actualization and the "gestalt" of the organism-environment interaction, to the phenomenology of Snygg and Combs, to the notions regarding self introduced by Harry Stack Sullivan, and to several other of his theoretically oriented predecessors. Drawing upon previous efforts in the field, he based his theory upon three variables: (1) the organism or "total" individual, (2) the phenomenal field, and (3) the self, which is a differentiated part of the phenomenal field. This organism is conceived of as having one basic striving, that of maintaining or enhancing itself. Rogers feels that the best vantage point for understanding the behavior of an organism is through that organism's "internal frame of reference," and therefore, one must deal with the self concept. This internal frame of reference is viewed, after differentiation through organism-environment interaction, as capable of directing or channelizing human behavior.

Rogers hypothesizes that "adjustment" is dependent upon the organism's ability to assimilate all experiences on a symbolic level, translating them into a consistent relationship with the self. Much of Rogers' theorizing is directly associated with his techniques of psychotherapy, a process which he describes as "client-centered." But, by virtue of scope alone, his theory of personality has stood as the most complete of those for general use by clinical psychologists with self-as-object being the primary human variable.¹

It is the purpose of the succeeding review of the literature to discuss the use of the term self-concept as it relates to psychopathology. It is felt that if this area is to be fruitful, it must provide information and definition not only of the average or "normal" person, but must also encompass the many and varied forms of deviations in human behavior categorized under the rubric psychopathology. That is, self concept theory should offer a framework in which all the various aberrations from normal behavior may be clearly understood.

Miskimins (1967) introduced a novel self-concept measurement technique, which, in addition to allowing duplication of variables typically measured, permits the assessment of other self-concept variables which serve to discriminate heretofore undistinguishable psychopathological categories. The

¹Carl R. Rogers, Client-centered Therapy (Boston: Houghton Mifflin Company, 1951), pp. 481-533.

Miskimins Self-Goal-Other Discrepancy Scale (MSGO) measures the discrepancies in a person's alignment of: (1) his self-concept, (2) his goal self concept, and (3) his perception of how others evaluate him.¹

Since the MSGO appears to be the most comprehensive and detailed measurement technique available in this area, it was utilized in this study's attempt to predict treatment outcomes across the experimental groups.

The review of the literature will be conducted in two parts: the first consideration will be dealing with self concept and its relationship to the general term "adjustment;" and second, there will be a discussion of those studies which proceed beyond generalities and actually specify by various means certain classes or groups of deviant behaviors.

¹Radean W. Miskimins, op. cit. pp. 62-93.

CHAPTER II

CONCEPT OF ADJUSTMENT

The concept of adjustment provides the clinical psychologist with a very general tool for sorting out psychopathological conditions from the so-called normal state. It is obvious that "adjustment" is a very complex term, and that its definition is not without disagreement and ambiguity. In addition, the sorting process depends in large measure upon the clinical background and frame of reference used by the judges. For example, some researchers might define the "mal-adjusted" as those in treatment for psychiatric disorders as opposed to those not in treatment, while others may use scores from psychological tests to make their selection. The reader is thus asked to bear in mind the different approaches to establishing the criteria of adjustment when appraising the various studies presented below.

It may be noted that despite the many problems faced in defining the term adjustment, most self concept theorists agree that low self-regard or high self-ideal discrepancy should be indicative of, or an aspect of, the lack of adjustment. The reverse of this, i.e., high self-regard as an indicator of good adjustment, however, is not a generally agreed upon postulate. This reverse may simply represent some "defense" or denial of problems which may in fact be

be part of a serious maladjustment.¹

The following research are presented in an effort to provide a cross-section of approaches to the assessment of self and to elucidate the empirical conclusions to date.

Test-defined adjustment. Block and Thomas (1955) explored precisely the issue at hand in their article entitled "Is Satisfaction with Self a Measure of Adjustment."² Maladjustment, as defined by these authors, was indexed by MMPI scale scores. Two weeks after administering the MMPI to a group of 56 college students, these same subjects completed self and ideal Q-sorts. They report that individuals expressing self-dissatisfaction earned significantly higher scores on the Hysteria, Depression, Psychopathic Deviate, Psychasthenia, and Schizophrenia scales of the MMPI. They did note, however, that this relationship appeared curvilinear in that there existed a small group of exceptionally high self-ideal congruence who appeared to be "deniers" and "suppressors."³

Zuckerman and Monashkin (1957) essentially replicated the above findings and then further refined their adjustment criterion. Using a sample group consisting of 43 psychiatric patients, they found negative correlations between self-acceptance (measured by a scale these authors developed) and

¹Jane Loevinger and Abel Ossorio, "Evaluation of Therapy by Self-Report: a Paradox," Journal of Abnormal and Social Psychology, LVIII (May, 1959), 392-394.

²Jack Block and Hobart Thomas, "Is Satisfaction with Self a Measure of Adjustment?" Journal of Abnormal and Social Psychology, LI (September, 1955), 254-259.

³Ibid., p. 257.

scores on the depression, Psychasthenia, Schizophrenia, and Social Introversion scales of the MMPI. They also speak of a "high self-acceptor" as defensive, acting out, externalizing, and generally, a maladjusted person. They also defined adjustment using an "external criterion": a rating of adjustment based on the patients' case histories. They tried to include such variables as severity of symptoms, bizarreness, chronicity, and premorbid functioning to arrive at their summary rating. Adjustment, thus defined, was positively correlated with self acceptance.¹

Rosenberg (1962) used the various scale scores from the California Psychological Inventory as his measure of maladjustment.² He reported that the scales Dominance, Capacity for Status, Sociability, Sense of Well-being, Self control, and Achievement via Conformance were all significantly negatively correlated with the degree of difference between perception of self and ideal self. He constructed the latter measure, a rating scale based on the statements "Myself As I Am" and "An Ideal Person." Rosenberg concluded that "deprivation of self is reflected in a CPI profile pattern which is indicative of maladjustment."³

¹Marvin Zuckerman and Irwin Monashkin, "Self-Acceptance and Psychopathology," Journal of Consulting Psychology, XXL (April, 1957), 145-148.

²Leon A. Rosenberg, "Idealization of Self and Social Adjustment," Journal of Consulting Psychology, XXVI (October, 1962), 487.

³Ibid.

Suinn and Hill (1964) were interested in the relationship between self-acceptance-acceptance of others, and anxiety, the "universal psychological symptom" or indicator of maladjustment. They administered the Taylor Manifest Anxiety Scale (Taylor, 1955), the Sarason General Anxiety Questionnaire (Sarason, 1957), and the Phillips Self-Other Questionnaire (1951) to 92 college students. The authors report a significant high negative correlation between self acceptance and level of anxiety for both anxiety scales. Further, acceptance of others is also negatively correlated with anxiety, but not to the high degree found for self-acceptance. Using the discrepancy scores provided by contrasting acceptance of self and acceptance of others they also obtained only moderately high correlations. Suinn and Hill note that the lower correlations regarding acceptance of self and the discrepancy scores appear to have been brought about by very anxious subjects who tended to have very low self-acceptance and concurrently were extremely accepting of others.¹

Adjustment defined by hospitalization. Tolor (1957) used the Who-Are-You scale (Bugental and Gunning, 1955) to test his notion that for high adjustment one must meet two self concept requirements: a person must understand his own unique qualities as an individual and should understand how

¹Richard M. Suinn and Hunter Hill, "Influence of Anxiety on the Relationship between Self-Acceptance and Acceptance of Others," Journal of Consulting Psychology, XXVIII (April, 1964), 116-119.

he is related to the general social group.¹ The W-A-Y test was administered on an individual basis to all subjects in three groups: 60 neuropsychiatric patients (mixed group of neurotics, psychotics, organics, etc.), and 45 control subjects from orthopedic wards (to control for possible psychosomatic illness in the second group). Each subject was asked to give three responses to the questions "Who are you?" and the responses were sorted into several categories including "Prestige," "Uniqueness," "Supportive Family," and "Dependent Family." Tolor states: "Emotionally disturbed patients appear to have a far less adequate self concept in terms of level of self-differentiation and group identification than do normals."² He noted that neuropsychiatric patients gave a significantly greater number of "own name" responses (82%), and significantly fewer responses coded for "group membership" and for "uniqueness."

Ziller, Megas, and DeCencio (1964) considered many of the same problems approached by Tolor, but used quite different methodology.³ Their primary tool was a construct sorting as suggested by Kelly (1955). Their subjects consisted of 25 neuropsychiatric patients and 23 "normals" matched by age and

¹Alexander Tolor, "Self-Perceptions of Neuropsychiatric Patients on the W-A-Y Test," Journal of Clinical Psychology, XIII (October, 1957), 403.

²Ibid., p. 405.

³Robert Ziller, James Megas, and Dominic De Cencio, "Self-Social Constructs of Normals and Acute Neuropsychiatric Patients," Journal of Consulting Psychology, XXVIII (February, 1964), 59-63.

sex, and such variables as self and certain "significant others" were utilized. These researchers report that neuropsychiatric patients significantly more often locate the self "negatively." The self and social constructs, taken together, of the patients in comparison with the normal sample indicate that the patients possess markedly lower self-esteem. Further, neuropsychiatric patients in contrast to normals tend to include fewer social elements. This, the authors conclude, demonstrates that "they are different and perceive themselves this way."¹

Summary. The review presented above seems to lead to one conclusion: maladjustment is reflected in the assessment of the phenomenal variable self concept. This finding is reported by all the research thus far reviewed, in the face of differing assessment techniques, definitions of adjustment, and research designs.

The results unanimously support the notion that adjustment is positively related to high self esteem. This relationship, however, is not one to one; that is, there appear to be notable deviations from this basic relationship. One may in part affix the blame to the measuring instruments used in that they are somewhat insensitive, subject to "faking," low in reliability, and the like. It does not, however, seem reasonable to turn to a criticism of the assessment techniques to try to fully explain the problems at hand. The

¹Ibid., p. 62.

often reported and distinct deviations from exactitude in prediction from phenomenal self-reports to level of adjustment leads one to more carefully evaluate the approaches being used. This may indicate that self-report is mediated in some cases and to varying degrees by some other psychologically-based variable. Further research is required to explicate this source of difficulty.

CHAPTER III

DIAGNOSTIC DIFFERENTIATION

The studies reviewed thus far dealt only in the dichotomy or continuum of maladjustment-adjustment. This section will provide a discussion of a representative group of researchers which provided differentiation within the class "maladjusted." The most common means for differentiation of subjects considered to be poorly adjusted has been through the use of the standard psychiatric diagnostic nomenclature. Thus, the review to follow will deal first with the more gross distinctions provided by this classification system, and secondly with those studies regarding specific diagnostic categories.

Major diagnostic groupings. The most common general differentiation of psychopathological states divides subjects into three groups--psychotics, neurotics, and character disorders. Chase (1957) proposed to study the relationship between self and ideal self for the above three groups. He formed, in essence, five groups: (1) 19 psychotics, (2) 20 neurotics, (3) 17 character disorders, (4) and (5) 50 normals divided into random halves. All subjects were administered the 50 self-referring items in Hilden's (1958) Q-sort set number 13 with instructions to sort the items for their concepts of self, ideal self, and average other person. The three primary predictive measures were derived from correlations between the sorts of: (1) self and ideal self (S-I), (2) self and average

other (S-AO), and (3) ideal self and average other (I-AO). Chase then specified that the S-AO sorts of one-half of the normals would be used to yield "normal sorts" for both concepts. This procedure allowed the computation of three other correlations: (1) concept of self vs. "normative" self (S-NS), (2) self vs. "Normative" average other person (S-NAO), and (3) average other person vs. "normative" average other person (AO-NAO).¹

Chase reports that the S-I, S-AO, S-NS, and S-NAO mean correlations of all three maladjusted groups were significantly lower than those obtained for the normals. He notes that the maladjusted subjects, while tending to perceive the concepts of the ideal self and of the average other person much like normal subjects, were inclined to perceive themselves as quite different from their ideals and from their concepts of the average other person. Relevant to diagnostic differentiation, Chase found it difficult to provide a clearcut distinction between his three maladjusted groups. He reports that psychotics yielded the lowest mean correlations, across the board, and were the most discrepant from normals. The neurotics had somewhat higher mean correlations between sorts, and the character disorders most closely resembled normals.²

Downing and Rickels (1956) present a study dealing with

¹Philip H. Chase, "Self Concepts in Adjusted and Maladjusted Hospital Patients," Journal of Consulting Psychology, XXI (December, 1957), 495-497.

²Ibid.

a mixed group of neurotics (depressed, somatic complaints, etc.) in an effort to provide some discriminations for this group of psychiatric patients. Using three groups of subjects-- 58 University Psychiatric Clinic neurotic patients, 62 City Hospital Psychiatric Clinic Neurotic patients, and 64 medical clinic patients as controls--they administered the Q-sort for self and ideal self. The sharpest contrasts emerged between the University and Psychiatric Clinic patients and the medical patient control group. Patients of the former group produced lower, more variable actual self scores, and higher, less variable, ideal self scores. Indices reflective of the self-evaluative behavior of the City Hospital patients in each case considered fell between those of the University Clinic and those obtained from medical patients.¹

Sarbin and Rosenberg (1955), also dealing with a mixed group of neurotics, found significant differences between neurotics and normals regarding their self-evaluative behavior. They formed two groups of college students, a normal volunteer group and a group diagnosed as neurotic and referred for therapy, and administered the 284 Gough Adjective Check List which they devised. They derived an "Index of Self Acceptance" (number of favorable adjectives checked

¹Robert W. Downing and Karl Rickels, "Q-Sort Patterns of Self-Evaluation in Three Neurotic Clinic Populations," Journal of Clinical Psychology, XXL (January, 1965), 89-96.

divided by the total), and an "Index of Self-criticality (number of unfavorable adjectives checked divided by the total). These authors report that the neurotic subjects were uniformly more self-critical and less self-accepting than were the control normals.¹

Neurotics and schizophrenics. Hillson and Worchel (1957) provided two patient groups for study--neurotics and schizophrenics. In all, they had three groups totaling 120 subjects: 47 normals, 37 neurotics, and 36 schizophrenics. The Self-activity Inventory (SAI; Worchel, 1957), consisting of 54 statements describing responses to the arousal of hostility, achievement, sexual, and dependency needs, was administered to all subjects. The subject was asked to indicate how much of the time the activity described was like him (self), how he would like to be (ideal), and how it was like other people (other). As found in other researches, neurotics gave significantly poorer self-appraisals than did normals. Hillson and Worchel further note that the schizophrenics gave self-appraisals much like normals. The self-ideal discrepancy was found to be significantly greater for neurotics than for normals or schizophrenics. These authors report that both patient groups evidenced ideals lower than normals, this reaching significance for the schizophrenics.

¹T. R. Sarbin and B. G. Rosenberg, "Contributions to Role-Taking Theory: IV. A Method for Obtaining a Qualitative Estimate of Self," Journal of Social Psychology, XLII (August, 1955), 71-81.

The only measure which successfully and significantly differentiated both patient groups from normals was the self-other discrepancy.¹

Friedman (1955) also studied the three subject groups utilized above. Using 80 statements derived from common TAT themes sorted for self and ideal, he found no significant differences in self-ideal correlations of schizophrenics and normals, although those of schizophrenics tended to be lower. Supporting the research above, he reports that neurotic subjects yielded significantly lower self-ideal correlations than either the schizophrenic or normal groups.²

Schizophrenics. Stimulated by early findings such as those above, there have been a large number of studies designed to more fully assess the phenomenal self concept in relation to the most prevalent of the psychoses, schizophrenia. Rogers (1958) used a genuinely unique technique to assess the self concept and ideal self concept in a group of schizophrenics. He constructed a wooden frame with a red square of glass and a blue square of glass. It was designed so the red square could slide on the frame and be slid directly behind the blue square. The subjects were asked to imagine the red square as the self and the blue square as the ideal self. Using 60

¹Joseph S. Hillson and Philip Worchel, "Self Concept and Defensive Behavior in the Maladjusted," Journal of Consulting Psychology, XXI (February, 1957), 83-88.

²Ira Friedman, "Phenomenal, Ideal, and Projected Conceptions of Self," Journal of Abnormal and Social Psychology, LI (November, 1955), 611-615.

subjects, 30 paranoid schizophrenics and 30 psychiatric aides as controls, he asked them to slide the red square to indicate the overlap, if any, between the two concepts. Rogers reports the paranoid schizophrenics did not have less overlap than normals as self concept theory would suggest, but, on the contrary, were found to have significantly higher self-ideal congruence than the normal group. He feels that through using this unique measurement technique he has tapped a more global level of personality, one which allows the easing of defensiveness.¹

As may be noted in the above research, subjects labeled "schizophrenic" are usually the paranoid type. In general, it appears that the studies using only the paranoid sub-class of schizophrenics find the most striking lack of self-ideal discrepancy. Tamkin (1957), in fact, used a very heterogeneous group of schizophrenics and found that the patient group had much lower self-acceptance scores than matched controls as measured by the Scott-Duke Questionnaire (unpublished excepting inclusion in Tamkin's article). This finding is contradictory to much of the research presented above, but Tamkin noted considerable overlap between his two groups and considerable variability of scores for both groups.²

¹ Arthur H. Rogers, "The Self Concept in Paranoid Schizophrenia," Journal of Clinical Psychology, XIV (October, 1958), 365-366.

² Arthur S. Tamkin, "Selective Recall in Schizophrenia and Its Relation to Ego Strength," Journal of Abnormal and Social Psychology, LV (November, 1957), 345-349.

Havener and Izard (1962) felt that the critical variable predicting unrealistic self-enhancement was that of paranoid defenses. A group of 20 hospitalized paranoid schizophrenics was selected on the basis of psychiatric diagnosis and a high score on the paranoid behavior factors of the Lorr Scale. A second group of 20 hospitalized non-paranoid schizophrenics was selected on the basis of diagnosis and a low score on the same factors of the above scale. The second control group was composed of 20 attendants at the same hospital. All subjects were given the Berger Scale (Berger, 1952) which has 36 items referring to self and 28 items used to measure distortion in perception of others. The Tennessee Department of Mental Health Self-concept Scale (Fitts, 1955) was used to measure distortions in the perception of self. The Paranoid-like Behavior Rating Scale (Havener, 1961) was also used in the measurement of the amount of unrealistic self-enhancement and projection taking place among normals (44 servicemen and 74 servicemen).¹

Havener and Izard report that the paranoid schizophrenics had significantly greater distortion in the perception of self and others than did the two control groups. Paranoids tended to overrate themselves more than did the controls, and in turn, tended to devalue others and perceive them as hostile and threatening (projection). These authors suggest that the

¹Philip H. Havener and Carroll E. Izard, "Unrealistic Self-Enhancement in Paranoid Schizophrenics," Journal of Consulting Psychology, XXVI (February, 1962), 65-68.

paranoid schizophrenic's unrealistic self-enhancement and consistently negative perceptions of others can be seen as a defense against complete loss of self-related positive affect and of interpersonal affect.¹

Manasse (1965) feels that much of the lack of high self-ideal discrepancy among certain psychotics may be credited to "environmental demands." He administered Hilden's (1958) Q-sort (number 13) to two groups of 51 hospitalized and non-hospitalized chronic schizophrenics, obtaining an actual-self sort, and expected-self sort, and an ideal-self sort. He reports that his prediction that self-regard was related to environmental demands and expectations was borne out in that: (1) hospitalized chronic schizophrenics have a higher correlation between self concept and ideal self concept than non-hospitalized chronic schizophrenics; and (2) hospitalized chronic schizophrenics have a higher correlation between actual self concept and how they feel the environment expects them to be than do non-hospitalized patients. Manasse reports that an environment that demands little of the individual, e.g., a psychiatric inpatient hospital, enables him to maintain a relatively positive self image. Conversely an environment that demands a great deal of the same individual tends to lead to a relatively negative self-image.²

¹Ibid.

²Gustave Manasse, "Self-Regard as a Function of Environmental Demands in Chronic Schizophrenics," Journal of Abnormal Psychology, LXX (June, 1965), 210-213.

Epstein (1955) conducted a study to differentiate normals and schizophrenics on both conscious and unconscious self-evaluative dimensions. His subjects consisted of 20 normals and 30 "delusional" schizophrenics, the two groups matched on age, sex, veteran status, institutionalization, and education. The conscious self-evaluations were obtained by having subjects directly rate their attitudes toward their own names, handwriting, voices, and selves. The "unconscious" self-evaluations were obtained by having the subjects rate their own disguised handwriting and voice as compared to other samples, and by noting length of time necessary to recognize their own names on tachistoscopic presentations of steadily increasing duration. Epstein reports that schizophrenics do not evaluate themselves significantly different from normals, as far as central tendency is concerned, on conscious measures of self regard. However, they show a greater tendency to place themselves at extremes. He further reports that schizophrenics evaluate themselves more highly than normals on all unconscious measures. Unconscious over-evaluation of self is common to all subjects, normal and mal-adjusted, but is found to a much greater degree among schizophrenics.¹

Maroney (1962) tried to study the self concept beyond the more usual concern with self-esteem. He was interested

¹Seymour Epstein, "Unconscious Self-Evaluation in a Normal and a Schizophrenic Group," Journal of Abnormal and Social Psychology, L (January, 1955), 65-70.

in the cognitive structure of the self concept, and more specifically, in "differentiation." He defined differentiation in four ways: (A) "Range" is the amount of information an individual has available and is willing to reveal when describing himself; (B) "homogeneity" is the degree to which self-attributes are perceived as similar, (C) "prominence" is the degree to which a self-attribute is perceptually dominant in the self concept; and (D) "valence" is the degree to which an individual evaluates himself positively or negatively.

Using 60 male Veteran Administration hospital patients he formed four groups: 15 adjusted surgical patients, 15 neurotics and character disorders, 15 mixed schizophrenics, and 15 paranoid schizophrenics. He administered to all subjects a measure of adjustment and a 208 item self inventory. Maroney reported that the variable of range provided no differentiation of his groups. The surgical control patients demonstrated significantly more homogeneity of the self concept, but this variable would not distinguish the three psychiatric patient samples. Prominence allowed no discrimination of the four groups, whereas valence differentiated normals from the mentally ill but would not differentiate among psychiatric diagnostic categories.¹

Alcoholism. It should be noted that there are relatively few studies available for specific diagnostic classifications other than schizophrenia. White and Gaier (1965) concerned themselves with body image and the self concept of alcoholics,

¹Robert J. Maroney, "Maladjustment and the Cognitive Structure of the Self-Concept" (unpublished Doctoral dissertation, The University of Colorado, Boulder, 1962), pp. 42-63.

primarily considered to be personality disorders, with differing intervals of sobriety. They used 104 male subjects, all members of Alcoholics Anonymous, with periods of sobriety ranging from 10 days to 17 years. Using Rorschach responses to index self concept, they report the "cathexis" toward the self is very high in the beginning of sobriety but decreases gradually and stabilizes after about a year of recovery from alcohol. However, the self concept may be considered to be generally positive throughout long-term sobriety as compared with the negative self-regard displayed by those once again drinking.¹

Wahl (1956) proposed that low self-regard is a crucial factor in the development of alcoholism. He demonstrated their low self-regard by pointing out high incidences of parental rejection, overprotection, large families with reported sibling rivalry, separation or loss of parents, and the like. However, he did not utilize self-reports or a control group of any kind, and thus there is considerable difficulty in assessing the validity of his reports.²

It is unfortunate, but the above studies represent all the self concept research to date dealing with alcoholics.

¹William F. White and Eugene L. Gaier, "Assessment of Body Image and Self-Concept among Alcoholics with Different Periods of Sobriety, Journal of Clinical Psychology, XXI (October, 1965), 374-377.

²C. W. Wahl, "Some Antecedent Factors in the Family Histories of 109 Alcoholics," Quarterly Journal of the Study of Alcoholism, XVII (February, 1956), 643-654.

Depressive syndromes. Laxer (1964) provides a study dealing primarily with depressive patients. He used a test-retest (5 week interval) design with Osgood's (1957) semantic differential scale as his primary tool. He compared a group of 37 depressives (primarily neurotic) with 37 paranoid schizophrenics, 99 mixed diagnosis patients, and 41 normals. In order to assess improvement he considered discharge dates and scores from the MACC Behavioral Adjustment Scale (Ellsworth, 1959). Laxer reports that on initial measurement the depressives yielded the lowest real self rating and high incongruence between real self and ideal self. Regarding the three factors of the semantic differential as specified by Osgood, evaluation, potency, and activity, depressives view themselves as "bad, weak, and passive." Paranoids, on the other hand, began with a relatively high real self rating and high self-ideal congruence. Laxer further reports that from initial testing to retesting the depressives' self regard improved markedly, thus decreasing self-ideal discrepancy. Concurrently, their adjustment ratings improved. To the contrary, the other three groups changed relatively little on all self concept and adjustment measures. Finally, the author reports that changes in self-ideal discrepancy were almost entirely dependent upon changes in the real self; i.e., the correlation between improvement and change in the ideal self was not significant.¹

¹Robert M. Laxer, "Self-Concept Changes of Depressive Patients in General Hospital Treatment," Journal of Consulting Psychology, XVIII (June, 1964), 214-219.

Summary. It is clear that phenomenal self concept variables allow some differentiation between various psychiatric diagnostic groups. Reasonable theorizing would predict a linear downward trend as one goes from normals to neurotics to psychotics (i.e., more discrepancy the more severe the pathology). This, however, is obviously not the case. Indeed, many studies have reported groups of psychotics, notably paranoid schizophrenics, that manifest levels of self-regard comparable to, if not higher than, normals. It appears that self-regard is related to adjustment in an essentially curvilinear fashion. But even this is not an infallible description of the relationship in that there have been demonstrations of both certain neurotics with normal self-regard and some psychotics with extremely low self-regard. There are, nonetheless, certain generalities available regarding the use of self concept approaches to diagnostic differentiation. A brief list of a few salient generalities generated from the above research follow.

Neurotics, as a general psychiatric classification, prove to have lower self-regard than comparable normals. They have lower opinions of themselves, demonstrate higher self-ideal discrepancy or lower self-ideal correlation, and have less stable self concepts. For the most part, little is known about the self concept of psychotics with diagnoses other than schizophrenia. In general, when a mixed group of schizophrenics is used as a study group, the results prove to

to be inconclusive and in some instances contrary from study to study. It would appear from the research above that much of the difficulty in interpretation is generated by one subgroup of schizophrenics, those evidencing paranoid idealization. The paranoid type of defensive system seems to allow an individual high self-regard and minimal self-ideal and self-average other discrepancy in spite of the realities of this person's existence. In general, it appears that the alcoholic most closely resembles the neurotic, evidencing low self-regard and considerable self-ideal discrepancy. Though little research has been done with depressive patients, they seem to demonstrate extremely low self-regard.

There must, of course, be questions regarding the adequacy of the presently universally accepted psychodiagnostic classification system. It seems clear from the above research that there is considerable need for further study in this area if self concept theory and related practical techniques and measurement is to survive and prove clinically valuable.

CHAPTER IV

METHODOLOGY

As mentioned above, there is considerable need for further research in the area of self-concept and its application to psychopathology. The present study will attempt to lend support to the notion that a person's concept of self is an effective indicator of at least one key aspect of treatment outcome--psychiatric recidivism.

It is felt that a brief description of the Miskimins Self-Goal-Other Discrepancy Scale would be useful prior to the presentation of the specific hypotheses of this research.

Scale. The Miskimins Self-Goal-Other Discrepancy Scale is a psychometric device dealing with the "Self Concept." This measure represents in several respects a departure from techniques presently popular in the field. The three letters, S, G, O, refer to self concept, the goal self concept, and the perceived responses of others, respectively. The three variables utilized in the construction of the scale have been drawn directly from a theoretical system proposed by Miskimins (1967), and in fact, represent its major systematic components.¹

The theory, or more correctly, "description," upon which the MSGO has been based is essentially behavioristic. The focus of this framework is the object self, and it is

¹Radean W. Miskimins, "A Precip on a Description of the Self" (unpublished paper, University of Colorado, Boulder, 1967), pp. 1-7.

maintained that a description of an individual's self may be obtained by observing the manner in which he behaves toward this "object." Miskimins holds that there is no need to probe "consciousness" or any form of "inner self," but rather only the demand for careful and detailed observation of human behavior. Hence, the responses obtained by the administration of the MSGO amount simply to instances of self-directed behavior elicited by a set of standardized stimuli.

Given the self as the center of a descriptive system, Miskimins further differentiates this concept into three elements. The first, and most influential in the formulations, is the "Self Concept." This refers to the concept which an individual holds regarding himself as a person. He feels it is conceptually more useful to envision the self concept as referring not to one, but to a large number of concepts about the self.¹ These could potentially be mapped out in terms of their generality, with higher order concepts encompassing a large number of more specific concepts of the self. Miskimins believes it is conceivable that all the many and varied notions a person has regarding himself may be subsumed under one superordinate concept. "Operationally, the Self Concept takes the form of the constellation of actional and verbal behaviors which a person directs towards himself."² The self

¹Radean W. Miskimins, Manual: MSGO Discrepancy Scale (Fort Collins, Colorado: Rocky Mountain Behavioral Science Institute, 1968), p. 1.

²Ibid.

concept is represented by the letters "SC."

The second element of the self which must be defined is the "Goal Self Concept." This refers to the concept which a person holds regarding himself as he would like to be. Miskimins did not use the similar term "Ideal Self" because of the obvious social desirability connotations of the term "ideal," and more important, "because of the repeated usage in the literature of normative rather than idiographic approaches to the establishment of an ideal self."¹ Further, Miskimins assumed that the meaningfulness of an ideal is an individual matter, and that each person selects goals which affect his behavior and these may in fact be deviant from cultural ideals. Thus, he proposed that it is the goal self concept (GSC) which in all cases describes behavior and that the ideal self, as commonly used, demonstrates this utility only in the majority of cases.² The GSC is also considered as comprising a number of concepts regarding an individual's goals for himself, and these, too, vary in their generality. "Operationally, the Goal Self Concept takes the form of the constellation of actional and verbal behaviors which a person directs toward himself as he would like to be."³ The GSC, like the SC is dealt with behavioristically, i.e., does not represent some mystical inner agent.

The term "Perceived Responses of Others" or "PRO" constitutes the third major element of the self. Every person

¹Ibid.

²Ibid., p. 2.

³Ibid., p. 3.

is seen as holding concepts of himself as he feels others perceive him. These concepts, credited to others, are viewed as varying from complete agreement with those he holds about himself to those of considerable deviation. Miskimins maintains that the concepts held by an individual regarding the perceptions of him held by those around him vary in generality, and again, may be dealt with through observation of behavior.

"Operationally, the Perceived Responses of Others takes the form of the constellation of actional and verbal behaviors which a person directs toward himself as he feels others view him."¹

The three constellations of constructs comprising the self outlined above, are viewed as the major components in a descriptive system. Given one area of concern, for example, "ability to be a good host," there is available: (1) the person's evaluation of himself, (2) the person's goals for himself regarding this activity, and (3) the person's perceptions of others' evaluation of his ability, i.e., the results of his interactions with his social environment. It is postulated that there are (typically) discrepancies in the alignment of the three elements of the self, and further, that the greater the discrepancy existing, the greater the "tension" existing. The major part of the above mentioned descriptive system is devoted to considerations of the various forms of discrepancy and their role in psychopathology. "Indeed, these

¹Ibid.

tensions serve as the bases for understanding, i.e., describing, a great portion of human behavior."¹

In summary, the MSGO was constructed on the basis of the demand created by a particular theoretical framework. It stipulated measurement of three proposed elements of self to allow testing of the various aspects of this descriptive system. "There did not exist a published instrument which could directly and efficiently meet this need, and hence, the construction of the MSGO was undertaken."²

The hypotheses being tested involve the predictive ability of five "self" factors measured by the MSGO. Table I briefly summarizes these five factors.

¹Ibid.

²Ibid.

TABLE I
SUMMARY OF FIVE MSGO FACTORS

MSGO Factor	Interpretation
1. Self-Goal plus	<u>SC-GSC* Discrepancy: Culturally Typical Goals</u> (similar to the commonly used "Self-Ideal" discrepancy, i.e., factor 1 is related to all self-goal positive discrepancies). High scores on this factor are significantly correlated with neurotic diagnoses.
2. Self-Goal minus	<u>SC-GSC* Discrepancy: Culturally Deviant Goals</u> (based on rejection of usual or typical goals, i.e., factor 2 is based on self-goal negative discrepancies). High scores on this factor are significantly correlated with personality disorder and psychotic diagnoses.
3. Self-Other plus	<u>SC-PRO* Discrepancy: Accepting Others</u> (others generally overvalue him, do not know him as he "really" is, i.e., factor 3 is related to self-others' evaluation of self positive discrepancies). High scores on this factor correlate significantly with the neurotic and psychotic depressive diagnoses.
4. Self-Other minus (Specific)	<u>SC-PRO Discrepancy: Critical Others--Specific</u> , interpersonal, affective aspects of self (others generally criticize him as regards his social skills, his emotional stability, his empathy for others, etc., i.e., factor 4 is based upon self-others' evaluation of self negative discrepancies). High scores on this factor correlate significantly with most psychotic diagnoses.
5. Self-Other minus (Global)	<u>SC-PRO Discrepancy: Critical Others--Global</u> (relates to basic overall evaluations, and he feels that others regard him as "completely" deficient, i.e., factor 5 is related to self-others' evaluation of self negative discrepancies for the "General" items). High scores on this factor correlate significantly with delusional psychotic diagnoses.

*SC refers to self concept, GSC to goal self concept, and PRO to perceived responses of others

Hypotheses. The specific predictions hypothesized for the relationship of the self concepts of psychiatric patients and their treatment outcomes are:

1. Psychotics will show significantly higher initial discrepancy on the Self-Other minus (specific) factor, and on the Self-Other minus (global) factor, than non-psychotics.
2. Non-psychotics will show significantly higher initial discrepancy on the Self-Goal plus factor, and on the Self-Other plus factor, than psychotics.
3. There will be no significant differences between the psychotic and non-psychotic groups on the Self-Goal minus factor.
4. Non-recidivist psychotics will show both significantly lower initial discrepancy on the Self-Other minus (specific) factor and on the Self-Other minus (global) factor, and significantly greater positive change on these factors than either recidivists or long staying psychotics.
5. Non-recidivist psychotics will show both significantly higher initial discrepancy on the Self-Goal plus factor, and on the Self-Other plus factor, and significantly greater negative change on these factors than either recidivists or long staying psychotics.
6. There will be no significant differences among the non-psychotic groups for either initial measures or

change scores on the Self-Other minus (specific) factor, and on the Self-Other minus (Global) factor.

7. Non-recidivist non-psychotics will show both significantly lower initial discrepancy on the Self-Goal plus factor and on the Self-Other plus factor, and more positive changes on these factors than will either recidivists or long staying non-psychotics.

These hypotheses were derived from the above review of literature, and from the nature of the above five MSGO factors.

Subjects. The patient samples were drawn from the patient population located at Fort Logan Mental Health Center, Denver, Colorado. Eighty patients were selected and divided into the six study groups--20 long staying psychotics, 10 long staying non-psychotics (i.e., psycho-neurotic and personality disorders), 14 recidivist psychotics, 7 recidivist non-psychotics, 10 non-recidivist psychotics, and 19 non-recidivist non-psychotics. The 29 non-recidivists were randomly selected from former patients who, at the time of this research, were discharged and had remained discharged for at least two years. The 21 recidivists were randomly selected from patients who, at the time of this research, had been readmitted to a psychiatric institution within one year after discharge from Fort Logan. The 30 patients classified as long stayers were randomly selected from persons

who, at the time of this research, had remained on the hospital roles for at least two years without discharge. Due to the size of the N, no demographic breakdown was attempted.

Procedure. As part of a routinely administered battery of questionnaires, all subjects in the patient groups were given the MSGO soon after their admission to Fort Logan. The mean length of time between admission and MSGO administration was approximately one month. They were again given the instrument six months after their first significant upward transfer. A significant upward transfer is defined as a move from a more intensive treatment modality to a less intensive treatment modality, e.g., from inpatient status to outpatient status.

The instructions were read to all subjects and example items were carefully completed.

CHAPTER V

RESULTS

The mean scores for the six study groups and relevant combinations of these groups on all factors for the first MSGO administration are reported in Tables II and III. A two by three analysis of variance was utilized to test for differences among the means of the six groups on each factor.

TABLE II
SUMMARY OF MEAN SCORES ON FIVE MSGO FACTORS
FIRST ADMINISTRATION

MSGO FACTOR	PLS	PR	PNR	NPLS	NPR	NPNR
1. Self-Goal plus	29.50	34.36	38.80	54.51	44.14	42.84
2. Self-Goal minus	2.65	0.29	1.5	1.10	0.00	0.16
3. Self-Other plus	7.50	6.21	8.40	14.2	6.71	12.05
4. Self-Other minus (Specific)	10.35	7.35	10.4	6.00	6.71	6.95
5. Self-Other minus (Global)	2.65	1.93	3.10	1.4	1.57	2.00

TABLE III
SUMMARY OF MEAN SCORES ON FIVE MSGO FACTORS
FIRST ADMINISTRATION

MSGO FACTOR	MEAN SCORES			MEAN SCORES	
	Psy- chotics	Non-Psy- chotics	Long Stayers	Recid- ivists	Non-re- cidivists
1. Self-Goal plus	33.16	46.33	37.83	37.62	41.45
2. Self-Goal minus	1.64	0.39	2.13	0.19	0.62
3. Self-Other plus	7.29	11.61	9.73	6.38	10.79
4. Self-Other minus (Specific)	9.48	6.64	8.9	7.29	8.14
5. Self-Other minus (Global)	2.52	1.75	3.83	1.81	2.38

Due to the unequal N's, the method of least squares was utilized to correct the anovars (see Edward's, 1960). Only one of the five anovars resulted in a significant F ratio. The Self-Goal plus factor was the only factor which significantly differentiated the six groups. Table IV presents a summary of these results. The results were supportive of three of the seven hypotheses. Non-psychotics yielded significantly higher initial discrepancy on the Self-Goal plus factor than psychotics, and, though not statistical significant, tended to receive higher mean scores on the Self-Other plus factor. As predicted, there were no significant differences among the

non-psychotic groups for the initial measures on the Self-Other minus (Specific) factor or on the Self-Other minus (Global) factor. And as was expected, no significant differences obtained between the psychotics and non-psychotic groups on the Self-Goal minus factor.

Contrary to the hypothesis, psychotics did not show significantly higher discrepancy on the two Self-Other minus factors than the non-psychotics, though the mean score differences were in the predicted direction.

Non-recidivist psychotics did not demonstrate significantly lower initial discrepancy on factors 4 and 5, or higher discrepancy on factors 1 and 3, than either recidivists or long staying psychotics, contrary to the hypotheses. Factors 1 and 3 did not significantly differentiate the non-psychotic groups, contrary to the prediction.

TABLE IV
SUMMARY OF 2 x 3 ANALYSIS OF VARIANCE
FIRST ADMINISTRATION

MSG0 VARIABLE	F_a^1	p_a	F_b^2	p_b	F_{axb}^3	p_{axb}
1. Self-Goal plus	10.10	<.001	0.01	n.s.	2.43	<.10
2. Self-Goal minus	1.63	n.s.	1.69	n.s.	0.17	n.s.
3. Self-Other plus	2.15	n.s.	0.48	n.s.	0.83	n.s.
4. Self-Goal minus (Specific)	1.39	n.s.	0.18	n.s.	0.14	n.s.
5. Self-Goal minus (Global)	1.71	n.s.	0.46	n.s.	0.12	n.s.

- 1) Analysis between diagnosis
2) Analysis between treatment outcome
3) Interaction

The mean scores for the six experimental groups and relevant combinations of these groups on the five factors for the second MSG0 administration are reported in Tables V and VI. A 2 x 3 analysis of variance was again utilized. As before, only one of the five anovars significantly differentiated the six groups. The Self-Other plus factor was the only factor that yielded a significant F ratio.

TABLE V
SUMMARY OF MEAN SCORES ON FIVE MSGO FACTORS
SECOND ADMINISTRATION

40

MSGO FACTOR	PLS	PR	PNR	NPLS	NPR	NPNR
1. Self-Goal plus	30.85	25.50	27.4	38.3	29.29	28.53
2. Self-Goal minus	0.80	0.71	0.80	0.70	0.71	1.16
3. Self-Other plus	6.7	5.15	4.90	13.90	5.86	8.21
4. Self-Other minus (Specific)	6.75	3.14	2.80	5.10	4.00	2.21
5. Self-Other minus (Global)	2.05	0.79	1.40	2.05	1.71	0.68

TABLE VI
SUMMARY OF MEAN SCORES ON FIVE MSGO FACTORS
SECOND ADMINISTRATION

MSGO FACTOR	Psy- chotics	Non-Psy- chotics	Long Stayers	Recid- ivists	Non-re- cidivists
1. Self-Goal plus	28.36	31.39	33.33	26.76	28.14
2. Self-Goal minus	0.77	0.94	0.77	0.71	1.03
3. Self-Other plus	5.79	9.33	9.10	5.38	7.07
4. Self-Other minus (Specific)	4.71	3.36	6.20	3.43	2.40
5. Self-Other minus (Global)	1.50	1.25	2.03	1.09	0.93

Table 7 presents a summary of these results.

Two of the five relevant hypotheses were supported. As was hypothesized, no significant differences obtained among the non-psychotic groups on factors 4 and 5, and between the psychotic and non-psychotic groups on factor 2.

Though not predicted for the second MSGO Administration, non-psychotics yielded significantly higher discrepancy on factor 3 than psychotics.

TABLE VII
SUMMARY OF 2 x 3 ANALYSIS OF VARIANCE
SECOND ADMINISTRATION

MSGO VARIABLE	F_a	P_a	F_b	P_b	F_{axb}	P_{axb}
1. Self-Goal plus	1.11	n.s.	1.38	n.s.	0.24	n.s.
2. Self-Goal minus	0.15	n.s.	0.23	n.s.	0.06	n.s.
3. Self-Other plus	5.77	< 0.25	2.19	n.s.	1.18	n.s.
4. Self-Other minus (Specific)	0.45	n.s.	2.35	< .10	0.05	n.s.
5. Self-Other minus (Global)	0.47	n.s.	1.20	n.s.	0.14	n.s.

Factors 1, 4 and 5 failed to significantly differentiate the six groups, contrary to the hypotheses.

The means scores for the six experimental groups is presented in Table VIII, and relevant combinations of these

groups on the five MSGO factors for the change scores (Administration 1 minus Administration 2) are reported in Table IX. A 2 x 3 analysis of variance was once again utilized. Since the change scores involved subtraction, a common number was added to each individual score across each factor, in order to avoid negative numbers. None of the five anovars yielded significant F ratios.

TABLE VIII
SUMMARY OF MEAN SCORES ON FIVE MSGO FACTORS
CHANGE SCORES FROM ADMIN. 1 MINUS ADMIN. 2

MSGO FACTOR	PLS	PR	PNR	NPLS	NPR	NPNR
1. Self-Goal plus	32.2	39.29	41.4	45.2	44.57	44.11
2. Self-Goal minus	6.95	4.57	5.3	5.4	4.29	4.21
3. Self-Other plus	21.3	18.93	23.5	20.4	20.8	23.84
4. Self-Other minus (Specific)	21.05	20.07	24.6	20.5	18.71	21.26
5. Self-Other	13.85	14.21	14.7	12.5	13.29	14.3

TABLE IX
SUMMARY OF MEAN SCORES ON FIVE MSGO FACTORS
CHANGE SCORES FROM ADMIN. 1 MINUS ADMIN. 2

MSGO FACTOR	Psy- chotics	Non-Psy- chotics	Long Stayers	Recid- ivists	Non-re- cidivists
1. Self-Goal plus	36.55	44.50	36.53	41.05	43.17
2. Self-Goal minus	5.82	4.55	6.43	4.47	4.59
3. Self-Other plus	21.05	22.31	21.0	19.57	23.72
4. Self-Other minus (Specific)	21.55	20.56	20.87	19.62	22.41
5. Self-Other minus (Global)	14.16	13.61	13.40	13.93	14.45

Table X presents a summary of these results. Contrary to the predictions, none of the five factors significantly differentiated the six groups.

TABLE X
SUMMARY OF 2 x 3 ANALYSIS OF VARIANCE
CHANGE SCORES FROM ADMIN. 1 MINUS ADMIN. 2

MSGO VARIABLE	F_a	p_a	F_b	p_b	F_{axb}	p_{axb}
1. Self-Goal plus	3.63	<0.10	0.69	n.s.	0.73	n.s.
2. Self-Goal minus	1.34	n.s.	1.86	n.s.	0.14	n.s.
3. Self-Other positive	0.21	n.s.	1.32	n.s.	0.39	n.s.
4. Self-Other minus (Specific)	0.37	n.s.	0.44	n.s.	0.88	n.s.
5. Self-Other minus (Global)	0.76	n.s.	0.66	n.s.	0.88	n.s.

CHAPTER VI

DISCUSSION

The results of this study did not support the hypothesis that psychotics would exhibit significantly higher initial discrepancy on the Self-Other minus (Specific) factor and on the Self-Other minus (Global) factor than non-psychotics, although the mean score differences were in the predicted direction. This was unexpected in as much as the above research has shown that these factors significantly correlate with most psychotic diagnoses. The failure to differentiate these groups might be a function of the size of the N, the patient sample, the instrument, a combination of these, or the result of some unknown variable. It seems apparent that further research is required to explain this inconsistency.

The hypothesis that non-psychotics would reveal significantly higher initial discrepancy on the Self-Goal plus factor and on the Self-Other plus factor than psychotics was partially confirmed. That is, only the Self-Goal plus factor significantly differentiated the two groups in the initial measure, with the mean score differences falling in the predicted direction for the Self-Other plus factor. The reverse of this was obtained from the second MSGO administration, with the latter factor yielding a significant difference, and the former factor, while not demonstrating a statistically significant comparison, revealed mean score differences in the

hypothesized direction. This affirmation was expected for two reasons: first, because high discrepancy on these factors (i.e., high anxiety and severe depression) has been shown to be a consistent characteristic of those individuals diagnosed as neurotic, and second, because psychotics, primarily those categorized as paranoid schizophrenics, have defensive systems which enable them to close the discrepancy gap to the point of "normal" appearance.

The hypothesis that no significant differences would obtain between the psychotic and non-psychotic groups on the Self-Goal minus factor was supported. This factor has been shown above to significantly correlate with personality disorder and psychotic diagnoses. In as much as the non-psychotic group included the former category, it was assumed that the two groups would not differ significantly.

Inconsistent with the prediction, non-recidivist psychotics did not demonstrate significantly lower initial scores on the two Self-Other minus factors, nor did they, as a group, manifest significantly greater positive change on these factors than either recidivists or long staying psychotics. Miskimins (1968) has demonstrated that high discrepancy scores on these two factors, especially the Self-Other minus (Global-others viewed as exceptionally hypercritical), are related to problems with others to a clearly psychotic, i.e., delusional, degree.¹ This led to the

¹Radean W. Miskimins, Manual: MSGO Discrepancy Scale (Fort Collins, Colorado: Rocky Mountain Behavioral Science Institute, 1968), p. 26.

conclusion that a great many of those psychotics who had not obtained discharge and those who had but were readmitted to a psychiatric hospital were troubled with severe mental illness and manifested delusional thought. It followed that those discharged patients that are delusional and thus face extreme problems in relationships with others cannot maintain a community adjustment and soon become readmits. Further, it seemed theoretically reasonable that those psychotic patients who were discharged and not subsequently readmitted, would demonstrate less maladaptive behavior and delusional thinking, and greater positive change over time than the other two groups. Since the results of the present study are at variance with the above research and hypothesizing, however, further research is clearly in order.

The assumption that non-recidivist psychotics would demonstrate significantly higher initial discrepancy on the Self-Goal plus factor and on the Self-Other plus factor, and significantly greater negative change on these factors than either recidivists or long staying psychotics was not supported by the present research results. A high discrepancy score on the former factor is maintained as being characteristic of high anxiety, and on the latter as indicative of severe depression. As previously mentioned, psychotics (again, primarily those classed as paranoid schizophrenics) in the main demonstrate a defensive system that enables them to deny discrepancy between SC-GSC, and SC-PRO. It was assumed, then,

that the non-recidivist psychotics would demonstrate more neurotic symptoms, i.e., manifest more discrepancy on these two variables, and thus be less severely ill. Further, it was felt that over time they would develop a more "realistic" (i.e., less defensive) outlook than either recidivists or long staying psychotics. In other words, they would have less severe psychotic defense mechanisms and would therefore be better oriented for successful treatment and early symptom remission (reduction of self discrepancies). The present results, however, have clearly shown that these assumptions have, in this study at least, no statistical basis.

The hypothesis that no significant differences would obtain among the non-psychotic groups for either initial measures or change scores on the two Self-Other minus factors was firmly supported. This was expected in that high discrepancy scores on these factors correlate significantly only with most psychotic diagnoses. That is, they purport to differentiate psychotic severity and delusional thinking from the non-psychotic, less maladaptive behaviors. Thus it was assumed that, as a group, non-psychotics would not differ significantly in their alignment of these factors.

Contrary to prediction, non-recidivist non-psychotics showed neither significantly lower initial discrepancy scores on the Self-Goal plus factor and the Self-Other plus factor, nor significantly more positive changes on these factors than either recidivists or long staying non-psychotics. It was

proposed that non-recidivist non-psychotics, as a group, would manifest less anxious and depressive behavior and consequently would demonstrate less alignment discrepancy than the other two non-psychotic groups. It was further hypothesized that inasmuch as they had not been rehospitalized, they most likely emitted more adaptive behavior, and thus would show greater improvement over time. Regardless of the value of this theorizing, the groups were not significantly differentiated.

The results of this experimental study are clearly negative in that only three of seven hypotheses were supported and that only two of fifteen anovars yielded significant F ratios. The researcher could have attempted to furnish possible explanations regarding the reasons for this study's failure, but to do so would have necessitated "off the cuff," redundant hypothesizing. In brief, little is known in this area of the relationship between self-concept and psychopathology. And in order to explain, at this stage of development at least, the "whys," post hoc, this researcher would have been forced to continuously sight the possibility of the influence of unknown variables, and to raise again questions regarding the sample size, the utility of the instrument, and the like. Therefore, the most reasonable conclusion to be made at this point is that further research is required.

CHAPTER VII

SUMMARY

The purpose of this thesis was to investigate the notion that a person's concept of self is an effective indicator of at least one key aspect of treatment outcome--psychiatric recidivism. The experimental results were in the main negative in that little discrimination could statistically be made between the groups. The only hypothesis involving group differentiation significantly supported was that non-psychotics would tend to exhibit lower self-regard and higher acceptance of others than psychotics. When viewed in light of the other more positive and often more varied research cited, however, such findings point primarily to the embryonic stage of knowledge in this area.

The review of the literature attempted to examine a number of research efforts representative of the use of the phenomenal self concept in describing and explaining the psychopathological states of man. It is quite clear that this approach to the study of human behavior has merit, as evidenced by the unanimity of supportive research findings. That is, in the face of considerable adversity, theoretical notions regarding the phenomenal self have generated several specific hypotheses which have found support in research (i.e., the high correlation between low self-regard and neurotic behavior). This is not to say that embodied in this approach

is the final answer for the field of psychology, for that has not been shown to be the case. Indeed, theory and research in this area is replete with what appears to be severe dilemmas and unanswerable questions. The problems of validity in measurement techniques, describing human behavior in purely phenomenological terms, and providing adequate controls for research, to name a few, serve to dilute, confound, and confuse the issues under consideration. Nonetheless, it should be emphasized that some of these problems, in addition to others of an even more complex nature, present difficulties for other theories and approaches to the study of personality as well.

In brief, there are many demonstrably valuable assets within this approach, and consequently, there is not sufficient cause to discard or dismiss them. Yet to be sure, there is remaining the task of further refinement in theory, assessment, and research, concurrent with careful consideration and elimination of the various problems now serving to handicap progress in the field.

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